

JONATHAN L. MASEL, MD

American Board of Urology Certified
4030 Sheridan Street, Suite C
Hollywood, FL 33021
Office 954-961-7500 Fax 954-964-8965
www.drmasel.com

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

Assignment of Benefits: I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my Medical Payments, Automobile Insurance (if applies), also known as Personal Injury Protection (hereinafter, PIP), policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes overdue interest and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy. The provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of Information: I hereby authorize this provider to: furnish an insurer, and insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, including but not limited to, documents, reports scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior expressed written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else are received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else are receive by the insurer the same day then the insurer is direct to pay this provider first before the policy is exhausted. In the even t the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name (Printed)

Patient's Signature (If patient is a minor, signature of parent/guardian)

Date

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *NOTICE OF PRIVACY PRACTICE OF JONATHAN L. MASEL, MD, PA*. Our *NOTICE OF PRIVACY PRACTICE* provides information about how we may use and disclose your protected health information. We encourage you to read it in full

If you have any question about our *Notice of Privacy Practices*, please contact our Compliance Officer at:

4030 Sheridan Street, Suite C
Hollywood, FL 33021
(954) 961-7500

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at the above address.

I acknowledge receipt o the *Notice or Privacy Practices* of Jonathan L. Masel, MD.

Signature: _____ Date _____
(Patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual’s acknowledgement, describe the good faith efforts made to obtain the individual’s acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ Date _____

An acknowledgment was not obtained because:

____ Patient refused to sign.

____ Patient was unable to sign or initial because:

____ There was a medical emergency (the staff member will attempt to obtain acknowledgement at the next available opportunity).

Other reason(s): _____

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CANCELLATION FEE POLICY

We value your time and patience when you come to visit the office. In return we ask that you please understand that we strive to serve you as efficiently as possible and need your help to do so. We ask that you please provide us with a 24 hour notice if you need to cancel or reschedule your appointment. This helps us to serve other patients who also require our services. In the event that you do not show and do not call to cancel/reschedule there will be a \$25 no show fee charged to you.

We appreciate your understanding of this matter and look forward to serving you.

I, _____, have read and understood the above policy. I understand that I will be charged if I fail to provide a 24 hour notice of cancellation.

Signature: _____
(Patient/parent/conservator/guardian)

_____ Date